



## MONTANA STATE PRISON HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS E-08.1	Subject: <b>URGENT/EMERGENT RESPONSE</b>
Reference: NCCHC Standard P-E-08, 2014	Page 1 of 4 and no attachments
Effective Date: November 1, 2010	Revised: June 1, 2017
Signature / Title: /s/ Cindy Hiner / Health Services Manager	
Signature / Title: /s/ Tristan Kohut, D.O. / Medical Director	

### I. PURPOSE

To respond to all medical emergencies and provide all inmates prompt access to emergent health care at all times.

### II. DEFINITIONS

Emergency – any medical or dental condition for which evaluation and treatment, as determined by health care staff, are immediately necessary to prevent death, severe or permanent disability, or to alleviate or lessen objectively apparent and disabling pain. Signs of objectively apparent and disabling pain may include visible injuries, high blood pressure, rapid heart rate, sweating, pallor, involuntary muscle spasms, nausea and vomiting, high fever, and facial swelling. Emergency also includes necessary crisis intervention for inmate's suffering from situational crises or acute episodes of mental illness.

Urgent/Emergent Health Care Request – an Urgent/Emergent Health Care Request for immediate medical attention based on the inmate's belief that a medical condition, symptom, or sign requires immediate attention by personnel trained in the evaluation or treatment of medical problems.

### III. PROCEDURES

#### A. Staffing

1. Montana State Prison will have at least one Registered Nurse (RN) available on-site 24 hours a day, seven days a week, to provide and or assist in emergency health care. During those hours when a physician is not on-site, the highest priority duty for the RN/LPN will be emergency care.
2. A physician will be available to provide on-site emergency care during the regular scheduled work days, or to provide scheduled on-call consultation 24 hours a day, seven days a week.

#### B. Urgent

1. Inmates will request medical attention for urgent/emergent health care needs from the correctional officer on duty, who will in all instances notify health care personnel.
2. Direct contact with the inmate by an RN/LPN or physician, in person, will be provided for all inmates requesting urgent/emergent medical attention. The RN/LPN or physician on duty will:
  - a. arrange to have the inmate brought to the medical unit for evaluation by health care personnel; or
  - b. arrange for health care personnel to go to the housing unit and transport the inmate to the medical unit for evaluation by health care personnel.
3. The health care personnel will document the evaluation on the Emergent Flow Sheet and attach any protocol flow sheets related to the urgent/emergent evaluation.

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4. Each urgent/emergent request will be documented in the Urgent/Emergent Tracking System log:
  - a. the Urgent/Emergent Tracking System log will be maintained in the medical unit for all unscheduled requests for medical care;
  - b. the Urgent/Emergent Tracking System log will include the name of the inmate, the inmate's ID/AO number, the housing unit, the time and date of the call, description of the complaint, final disposition of the inmate (i.e. back to housing, emergency room, etc.) and if a Primary Care Provider was notified;
  - c. all encounters must be documented in the Urgent/Emergent Tracking System log.
5. The PCP will review the Urgent/Emergent flow sheet to ascertain the following: indicated follow-up; documentation of inmates who have presented with urgent/emergent problems.
6. The PCP will initial and date the Urgent/Emergent flow sheet.
7. All completed documentation will be routed to Medical Records staff who will file it in the inmate medical chart.

### **C. Emergency**

1. Medical emergency responders will be notified immediately upon discovery of an inmate in acute distress (inmate down). Notification may be made by two-way radio or telephone.
2. Upon notification of a medical emergency within the institution, an RN/LPN or CHST will respond immediately to the scene with an emergency kit:
  - a. whenever possible, two medical staff members will respond to an emergency;
  - b. housing unit staff will arrange for emergency responders to have immediate access to the housing unit or area where the emergency has occurred. If safety and security issues are identified, custody staff will secure the area and allow emergency responders to have immediate access to the ill or injured inmate;
  - c. the RN/LPN/CHST will initiate emergency medical care when the area has been controlled by custody staff;
  - d. custody staff may assist with the movement and transportation of ill or injured inmates under the supervision of a licensed health care provider and CHST employed by MSP; and
  - e. inmates will not provide any direct inmate care and will not have access to any health care information.
3. Health care staff involved in the response will complete an Incident Report. The Incident Report is a custody form; therefore to maximize inmate confidentiality involved health care staff will complete the Emergent Flow Sheet providing the comprehensive medical information and send it to the medical records staff for filing.
4. If there is no physician or RN present, the CHST will determine the presence of the inmate's airway, breathing, and circulation (ABC's). CHST's will not make nursing judgments in connection with an emergency, however they may take the following immediate actions:
  - a. Initiate Cardiopulmonary Resuscitation (CPR), if indicated;
  - b. Control any bleeding;
  - c. Obtain vital signs.

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The CHST will contact the Emergency Treatment Area RN/LPN to report the inmate's condition and receive clinical direction regarding treatment and transportation.

5. The first responder to a medical emergency will take immediate action to preserve life. When responding to the aid of a person who appears to be choking or is unconscious and not breathing, the first priority is to restore an open airway.
6. CPR will be initiated in all cases of cardiac/respiratory arrest, except when the following signs of death are present:
  - a. rigor mortis;
  - b. dependent lividity as evidenced by venous congestion (i.e., bruising or reddish discoloration on dependent parts of the body);
  - c. tissue decomposition; and
  - d. obvious fatal trauma including, but not limited to, decapitation and incineration.

Health care providers will utilize the above criteria when deciding whether to initiate CPR. When there is a questionable or borderline case, health care staff will proceed with the initiation of CPR.
7. While preservation of a crime scene is a valuable investigatory tool, this will not preclude or interfere with the delivery of health care. Preservation of life takes precedence over preservation of the crime scene.
8. Emergency responders who initiate CPR will continue resuscitation efforts until one of the following occurs:
  - a. effective spontaneous circulation and ventilation have been restored;
  - b. resuscitation efforts have been transferred to other trained personnel who continue Basic Life Support;
  - c. care is transferred to a physician who determines that resuscitation should be discontinued;
  - d. the emergency responders are unable to continue resuscitation because of exhaustion or safety and security issues that could jeopardize the lives of others; and
  - e. a valid Do-Not-Resuscitate order is presented to the emergency responders.
9. If the inmate is unable to be resuscitated, the decision to terminate CPR will be made by a physician. Pronouncement of death will be made by a physician, according to acceptable medical standards.
10. If a physician is present, the physician will determine whether:
  - a. medical treatment will be continued at the facility; and
  - b. the inmate's condition warrants transport to an acute care facility outside of the institution.
11. Upon arrival at the Emergency Treatment Area, the RN/LPN will perform an assessment of the inmate's condition and determine whether or not the inmate's care can be continued in the Emergency Treatment Area:
  - a. this assessment must be documented on the Emergency Care Flow sheet;
  - b. additional progress notes will be used when space is insufficient;
  - c. the RN/LPN will continue emergency care until the physician on call is contacted for further instructions, or until a physician arrives at the scene to provide for the inmate's care; and
  - d. the RN/LPN will initiate the Emergency Care Flow sheet.

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12. If a physician is not immediately available, the RN on duty assumes responsibility for the emergency evaluation.
13. When it is determined that the inmate has a condition requiring services outside the scope of those available at the institution, and requires emergency transfer, the inmate will be transported to an acute care facility:
  - a. when transfer to an acute facility is required, the RN/LPN will notify the Command Post;
  - b. when an ambulance is required, Command Post staff will be notified of the level of emergency. The Shift Commander will coordinate transportation and custody requirements. Under no circumstances will custody requirements delay medical care in a life-threatening situation;
  - c. when the inmate is to be transported utilizing an MSP vehicle, the Command Post will be notified in order to coordinate custody requirements and a transport vehicle:
    - 1) this will be done within a time frame determined by the physician;
    - 2) the RN/LPN on duty will notify the nursing staff at the receiving acute care facility of the inmate's medical status at the time of departure from the institution;
    - 3) the facility physician will give a report to the emergency room physician, when possible, to ensure continuity of care.
  - d. When the decision to transport an inmate is made by the RN/LPN team in the absence of an on-site physician, the on-call physician will be notified by telephone as soon as possible;
  - e. the RN/LPN or designee will send a copy of the Emergent Flow Sheet to the receiving facility; and
  - f. all inmates seen in the Emergency Department will be followed up by a qualified health care professional within a timely manner to ensure appropriate implementation of the discharge orders and to arrange appropriate follow-up.
14. The Chief Medical Officer, designated lead clinician, or supervising RN will review the emergency room register Monday through Friday to determine if any specific medical records should be reviewed.
15. The logbook and Emergency Flow Sheet will be used by the nursing supervisor to perform at least quarterly training for the nurses to upgrade their skills:
  - a. records of inmates with a specific presenting complaint should be reviewed and utilized for this training, being sure to identify both strengths and opportunities for improvement in the current performance; and
  - b. a different incident should be reviewed through this process each quarter.
16. At the conclusion of each calendar month, the Health Care Manager or designee will conduct reviews of all incidents involving emergency medical transport for that month.
17. Monthly statistics will be gathered and reviewed regularly at CQI meetings.

#### **IV. CLOSING**

Questions concerning this operational procedure will be directed to the Health Services Manager.

#### **V. ATTACHMENTS** None